DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To:	Pharmacists	**Memorandum No**. **03-55 MAA**
	Managed Care Plans	**Issued**: September 1, 2003
	Regional Administrators	
	CSO Administrators	**For further information, go to:**
		http://maa.dshs.wa.gov/pharmacy/
From:	Douglas Porter, Assistant Secretary	
	Medical Assistance Administration	
Subject:	**New Version of Point-of-Sale**	

> In order to comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements, the Point of Sale (POS) system must change to the NCPDP* Version 5.1 claim format. Our vendor is committed to an October 16 implementation date for using Version 5.1. DSHS advises that pharmacies maintain existing processes as a contingency if implementation is delayed.

*NCPDP – stands for National Council for Prescription Drug Programs

Summary of changes

New Procedure Codes

HIPAA requires all healthcare payers to process and pay electronic claims using standardized format and codes. In order to comply, MAA will discontinue all state-assigned codes. Codes being replaced and their replacement codes are listed below and on the attached page replacements for the Prescription Drug Program Billing Instructions, dated February 2003.

Old Code	New Code	New EPA #	Description
4800A	T1999	870000864	Reusable compliance device or container
4801A	A9901	870000867	Filling fee for reusable compliance device
4802A	T1999	870000865	Non-reusable compliance device
4804A	T1999	870000866	reusable compliance device, extra large
4805A	S9445		Emergency Contraceptive Counseling
0857J	90862		Clozaril Case Coordination

Place of Service

Place of service codes have changed from one digit to two digits (field 24b on the HCFA-1500 claims form). See replacement page L.8 for the correct two-digit place of service code.

Pre-filling Syringes

Fees for pre-filling syringes can be billed on the HCFA-1500 claim form. **These fees are not billable on POS.**

- ✓ Each unit billed must be for a two week supply;
- ✓ Maximum units allowed per month is three;
- ✓ Use the following procedure code:

Description	Procedure Code	Maximum Allowable
Pharmacy compounding and dispensing services (to be used for pre-filling syringes)	**S9430**	$10.00 per unit

☞ **Note:**

- ✓ If additional fills are necessary for dose adjustment, indicate the comment **"Dose adjustment required"** in field 19 (*Reserved for Local Use* field) of the claim form.

- ✓ If additional fills are necessary due to multiple prescriptions/types, indicate the comment, "Multiple prescriptions/types required" in field 19 (*Reserved for Local Use* field) of the claim form.

- ✓ If an emergency fill is necessary resulting in less than a two-week supply, indicate the comment **"Emergency fill"** in field 19 of the claim form.

Payer Sheets

The attached Payer Sheets itemize values recognized by MAA. Use of these values will expedite processing of your claim.

Insurance Coverage Codes

The following Other Coverage Codes are changing:

Other Coverage Code	What is Changing?

2   **Other coverage exists - payment collected**
Use Other Coverage Code 2 if a payment was collected from the primary insurance. (Formerly used for capitated copays, which is now Other Coverage Code 8.)

4   **Primary insurance billing exceptions**
MAA is discontinuing Other Coverage Code 4. Should you have clients with a prepay* insurance plan for drug benefits, please call MAA's Coordination of Benefits Section at 1-800-562-6136 for billing assistance.

Prepay means that the client's identified insurance coverage policy requires the client to pay at the time of service, and the insurance reimbursement is made only to the subscriber.

7   **Other coverage exists – not in effect at time of service**
This is a new code. Other Coverage Code 7 is used if the provider bills the insurance for a non-covered date of service. This often occurs when the insurance is union-based and has lapses in coverage, or the coverage has terminated.

8   **Capitated contracted copayments**
This is a new code. Other Coverage Code 8 is used when the pharmacy has a capitated service agreement with an insurance company.
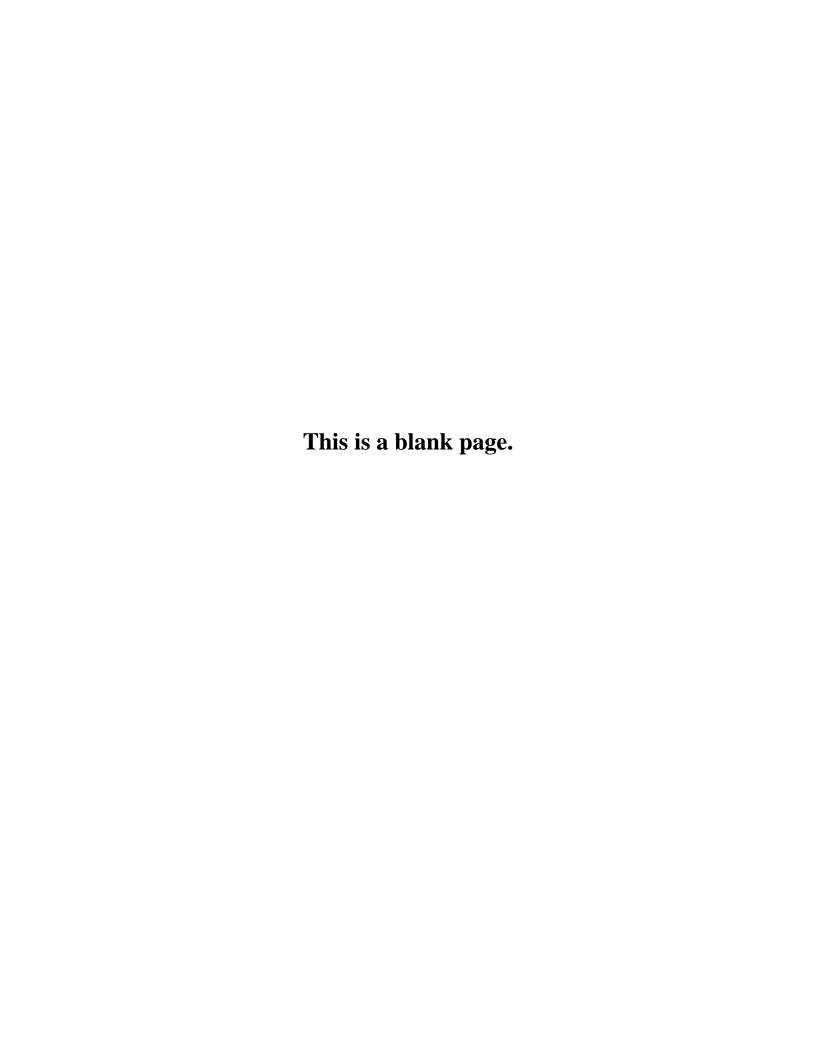
For a complete list of Coverage Codes, see replacement page J.17 attached.

Electronic Billing References

References to Electronic Billing are being removed as formats previously available are no longer available under HIPAA.

Replacement Pages for Prescription Drug Program Billing Instructions

Attached are replacement pages i-viii, C7-C8, D1-D2, E.3-E.4, G1-G4, G7-G8, H1-H2, H5-H6, J7-J8, J11-J14, J17-J20, Section K (all), and L7-L10 of MAA's Prescription Drug Program Billing Instructions, dated February 2003. To obtain this numbered memorandum electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

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Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)]

Where do I call to submit change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my hardcopy claims?

Division of Program Support
PO Box 9245
Olympia WA 98507-9245

What is the web site address for pharmacy information?

MAA's Pharmacy Web Site:
http://maa.dshs.wa.gov/pharmacy/

How do I find out more about MAA's Prescriptions by Mail program?

Providers Call: 1-888-327-9791
Clients Call: 1-800-903-8369
Or go to MAA's website:
http://maa.dshs.wa.gov/RxByMail/

Who do I call for prior authorization?

Pharmacy Prior Authorization Section
Drug Utilization and Review
(800) 848-2842

Backup documentation ONLY must be mailed or faxed to:
Pharmacy Prior Authorization Section
Drug Utilization and Review
PO Box 45506
Olympia WA 98504-5506
Fax (360) 586-2262

Who do I call to begin a Therapeutic Consultation Service (TCS) Review?

Toll Free (866) 246-8504

Who do I contact if I have questions regarding…

Payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
Email: providerinquiry@dshs.wa.gov
or call: (800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Real-time, on-line Point-of-Sale claims adjudication?

Affiliated Computer Services, Inc.
(ACS - formerly known as *Consultec*)
Technical POS Help Desk
(800) 365-4944

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Limitations on Certain Drugs

MAA has set limits on certain drugs based on FDA-approved indications.

To view MAA's current List of Limitations
on Certain Drugs
go to: http://maa.dshs.wa.gov/pharmacy

If you do not have access to the Internet, you may obtain a hard copy of MAA's List of Limitations of Certain Drugs by

Emailing: **Faxing:**
Provider Relations Unit   Provider Relations Unit
providerinquiry@dshs.wa.gov   (360) 586-1209

Writing to: **Calling:**
Provider Relations Unit   Provider Relations Unit
PO Box 45562   (800) 562-6188
Olympia, WA 98504-5562

Physicians and pharmacists should monitor the use of these drugs and counsel patients when the limits are exceeded. Prior authorization is required in order to exceed these limits.

See the Expedited Prior Authorization list (page H.5) for other limits on certain drugs.

Is it possible to receive early refills?
[Refer to WAC 388-530-1100(5)(b)(iii)]

MAA denies refills requested before 75% of the previously dispensed supply is scheduled to be exhausted.

However, the following circumstances are justification for early refills:

- If a client's prescription is lost, stolen, or destroyed (only once every six months, per medication).
- If a client needs a refill sooner than originally scheduled due to a prescriber dosage change. (The pharmacist must document the dosage change.)
- If a client is suicidal, at-risk for potential drug abuse, or being monitored by the prescriber.
- If a client needs a take home supply of medication for school or camp, or for skilled nursing facility clients.

For any other circumstance, the provider must contact MAA's Pharmacy Prior Authorization Section to request approval and a prior authorization number (see Important Contacts section).

Pharmacy providers have the right to ask clients for documentation relating to reported theft or destruction, (e.g., fire, earthquake, etc.). If a client residing in a skilled nursing facility has his/her prescription lost or stolen, the replacement prescription is the responsibility of the skilled nursing facility. Clients who experience difficulties in managing their drug therapy should be considered for the use of compliance devices (e.g., Medisets).

> 🗀 **BILLING**:
>
> **Hard copy billers** must enter one of the following justification descriptions in the *Justification/ Comments* field on the Pharmacy Statement [DSHS 13-714].
>
> **Point-of-Sale billers** must enter one of the following codes in the *Claims Segment, Prior Authorization Code* field.
>
> | Justification Description | Code |
> |---|---|
> | "Lost or Stolen Drug Replacement" | 5 |
> | "School or Camp" | 8 |
> | "Monitoring" | 8 |
> | "Suicidal Risk (SR)" | 8 |
> | "Take Home Supply (Skilled Nursing Facility Client)" | 8 |

Compliance Packaging

The Medical Assistance Administration (MAA), the Home Care Association of Washington (HCAW) and the Washington State Pharmacy Association (WSPA) developed the following guidelines in a cooperative effort to improve drug therapy outcomes for the most *"at-risk"* segment of the Medical Assistance population.

What is included in compliance packaging?
[Refer to WAC 388-530-1625(2)]

Compliance packaging includes:

- Reusable hard plastic containers of any type (e.g., Medisets, weekly minders, etc.); and
- Nonreusable compliance packaging (e.g., blister packs, bingo cards, bubble packs, etc.).

How do I determine if a client is eligible for compliance packaging?   **[Refer to WAC 388-530-1625(1)]**

Prescribers are encouraged to communicate to high-risk clients the need for compliance packaging if, in their professional judgement, such packaging is appropriate.

Clients will be considered high-risk and eligible to receive compliance devices if they:

- **Do not reside** in a skilled nursing facility or other inpatient facility; **and**
- Have one or more of the following representative disease conditions: Alzheimer's disease, blood clotting disorders, cardiac arrhythmia, congestive heart failure, depression, diabetes, epilepsy, HIV/AIDS, hypertension, schizophrenia, or tuberculosis.

  -AND-

- Concurrently consume two or more prescribed medications for chronic medical conditions that are dosed at three or more intervals per day; **or**
- Have demonstrated a pattern of noncompliance that is potentially harmful to the client's health. The client's pattern of noncompliance with the prescribed drug regimen must be fully documented in the provider's file.

Prefilling a syringe is not considered compliance packaging.
See page G.8 - Special Programs for Syringe Filling Guidelines.

How do I bill for compliance packaging?

To bill for compliance packaging:

1.   Bill on a HCFA-1500 claim form.
2.   Bill your usual and customary charge. Reimbursement will be the billed charge or the maximum allowable fee, whichever is less.
3.   Use the following procedure codes with the appropriate **Expedited Prior Authorization** number. Use of the EPA number is for billing purposes only and must be on the claim or the claim will be denied.

Procedure Description	Procedure Code	Expedited Prior Authorization #	Maximum Allowable
Reusable compliance device or container	T1999*	870000864	$6.00 maximum per device (limit of 4 per client, per year).
Reusable compliance device or container, extra large capacity	T1999*	870000866	$16.91 maximum per device (limit of 4 per client, per year).
Filling fee for reusable compliance device or container	A9901	870000867	$2.50 per fill (limit of 4 fills per client, per month).
Non-reusable compliance device or container	T1999	870000865	$3.00 (limit of 4 **fees** per client, per month) Includes reimbursement for materials and filling time. Bill one unit each time compliance packages are filled.

* May be billed in combination but not to exceed a total of 4 per year.

Written requests for a limitation extension should be sent to:

> Division of Medical Management
> Pharmacy Research Specialist
> PO Box 45506
> Olympia, WA 98504-5506
> Fax: (360) 586-2262

How do I bill for compounded prescriptions
[Refer to WAC 388-530-1500(4)(5)]

* Pharmacies must bill separately for ingredients used in compounded prescriptions using the 11-digit NDC for each ingredient.
* Bill only the quantity used for that ingredient. **Do not bill the combined total quantity.**

   MAA reimburses a dispensing fee for each ingredient. The additional dispensing fees are payment for the pharmacist's compounding time. MAA does not pay separate fees for compounding time or preparation fees.

> 📁**BILLING**:
>
> **Hard copy billers** must enter "Compound Prescription" in the *Justification/ Comments* field on the Pharmacy Statement [DSHS 13-714].
>
> **Point-of-Sale billers** must enter information in the Compound Segment.

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Special Programs/Services

Smoking Cessation for Pregnant Women

The Medical Assistance Administration (MAA) reimburses eligible providers for including smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination).

A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. MAA covers certain pharmacotherapy for smoking cessation as follows:

✓   MAA covers Zyban® only;

✓   The product must be prescribed by a physician, ARNP, or physician assistant;

✓   The client for whom the product is prescribed must be 18 years of age or older;

✓   The pharmacy provider must obtain prior authorization from MAA when filling the prescription for pharmacotherapy; and

✓   The prescribing provider must include both of the following on the client's prescription:

➢   The client's estimated or actual delivery date; and
➢   Indicate that the client is participating in smoking cessation counseling.

To obtain prior authorization for Zyban®, pharmacy providers must call:

Drug Utilization and Review
1-800-848-2842

Clozaril/Clozapine and Related Services

MAA reimburses pharmacists for Clozaril/Clozapine plus a dispensing fee.
Bill Clozaril/Clozapine using the appropriate NDC on either the POS system or the Pharmacy Statement [DSHS 13-714]. The DSHS 13-714 form is available for electronic download at: http://www.wa.gov/dshs/dshsforms/forms/eforms.html.

Any licensed or registered pharmacist with clinical experience in monitoring patient mental and health status may provide and bill case coordination (medication management) for clients receiving Clozaril/Clozapine.

Persons providing case coordination serve as a focal point for the client's Clozaril/Clozapine therapy. All services must be documented and are subject to quality assurance review. Case coordinators are expected to:

- Coordinate a plan of care with the client or the client's caregiver, the prescriber, and the pharmacy;
- Assure services are provided to the client as specified in the plan of care;
- Assure weekly blood samples are drawn, blood counts are within normal range, and client is compliant with plan of care;
- Follow-up with the client on missed medical appointments;
- Maintain detailed, individual client records to document progress;
- Provide feedback to the prescriber on the client's progress, immediately report abnormal blood counts, and client non-compliance; and
- Assure smooth transition to a new case coordinator, when necessary.

Use the following procedure codes to bill for Clozaril/Clozapine related services on a HCFA-1500 claim form or the appropriate electronic format:

Procedure Code	Description	Reimbursement
36415	Routine Venipuncture	per RBRVS fee schedule
90862	Case Coordination	$10 per week, per client
85022[1]	Blood Count (CBC)	per RBRVS fee schedule

☞ **Note:** Due to close monitoring requirements, MAA allows up to five (5) fills per month.

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[1] **Can be billed by CLIA certified laboratories only.**

Emergency Contraception Pills (ECP)

Emergency contraception pills are reimbursable through the MAA Point-of-Sale (POS) prescription drug system. To receive payment, pharmacies must bill MAA fee-for-service using the specific NDC and prescribing provider number 9777707. Pharmacies who are members of, or subcontract with, managed care plans must bill the prescription cost to the plans. MAA reimburses pharmacists for ECP plus a dispensing fee. Bill ECP using the appropriate NDC.

Emergency Contraception (EC) Counseling

When a pharmacist with an EC protocol approved by the Board of Pharmacy prescribes ECPs, the pharmacy may bill MAA for the counseling portion.

Prior to billing for EC counseling, MAA must have a letter or fax on file requesting reimbursement for EC counseling along with a copy of the pharmacist's approved protocol certificate from the Board of Pharmacy.

The request must state, "*Attached is the approved protocol certificate from the Board of Pharmacy,*" and must include the pharmacy's MAA provider number. Send the initial request and certificate copy to:

Medical Assistance Administration
Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562
FAX: (360) 586-1209

Use the following procedure code and diagnosis code to bill for EC counseling.

Diagnosis Code	Description	Procedure Code	Maximum Allowable
V25.09 Contraceptive Management	EC Counseling	S9445	$13.50

The counseling is a service-related item, not a drug, and must be billed on a HCFA-1500 claim form. The pharmacy must use its MAA-assigned provider number (beginning with a "6"), not the National Association of Boards of Pharmacy (NABP) number. The prescribing provider number 9777707 must be entered in *Referring Provider field* (field 17a), and diagnosis code V25.09 (contraceptive management) must be used.

Anti-emetics

Pharmacists with prescriptive authority for emergency contraception pills may prescribe and bill for selected anti-emetics only when these drugs are dispensed in conjunction with emergency contraception pills. MAA will reimburse the following only when they are prescribed and dispensed in the strength/dose form listed:

Meclizine hydrochloride	25 mg tablets
Diphenhydramine hydrochloride	25 mg tablets/capsules
Dimenhydrinate	50 mg tablets
Promethazine hydrochloride	25 mg tablets or 25 mg suppository
Metoclopramide	5 mg, 10 mg tablets
Prochlorperazine	25 mg suppository

Refills

Prescribers can authorize refills for up to one year; clients receive a reorder slip along with their medication. The slip must be mailed back to Medco Health, with refills usually taking about eight days. Medco Health recommends that its customers mail in their reorder slip when approximately two weeks of the existing prescription remain.

Customer Support

Toll-free support for prescribers……………………………………….... 1-888-327-9791

Medco Health, 24-hours a day, 7 days a week
   (except Thanksgiving and Christmas) toll-free support for clients……… 1-800-903-8639

Internet information for providers …………………………….......... www.medcohealth.com

MAA Customer Service Center, Olympia, 7 a.m.- 6 p.m., M-F………….. 1-800-562-3022

MAA Web site - explains this program, answers frequently
   asked questions, and has downloadable forms ………………….. http://maa.dshs.wa.gov/rxbymail

Pre-filling Syringes

Fees for pre-filling syringes can be billed on the HCFA-1500 claim form. **These fees are not billable on POS.**

- ✓ Each unit billed must be for a two-week supply;
- ✓ Maximum units allowed per month is three;
- ✓ Use the following procedure code:

Description	Procedure Code	Maximum Allowable
Pharmacy compounding and dispensing services (to be used for pre-filling syringes)	S9430	$10.00 per unit

☞ **Note:**

- ✓ If additional fills are necessary for dose adjustment, indicate the comment **"Dose adjustment required"** in field 19 (*Reserved for Local Use* field) of the claim form.

- ✓ If additional fills are necessary due to multiple prescriptions/types, indicate the comment, "Multiple prescriptions/types required" in field 19 (*Reserved for Local Use* field) of the claim form.

- ✓ If an emergency fill is necessary resulting in less than a two-week supply, indicate the comment **"Emergency fill"** in field 19 of the claim form.

Authorization

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Authorization does not guarantee payment.
All administrative requirements (client eligibility, claim timeliness, etc.)
must be met before MAA reimburses.

</div>

Who determines authorization status for drugs in MAA's drug file? [Refer to WAC 388-530-1200(1)]

MAA pharmacists, medical consultants, and the drug utilization review team evaluate drugs to determine authorization status on the drug file. MAA may consult with a drug evaluation unit, the Drug Utilization and Education (DUE) Council, and/or participating MAA providers in this evaluation.

How are drugs added to MAA's drug list?
[Refer to WAC 388-530-1200(2)(3)]

Drug manufacturers who wish to facilitate the evaluation process for a drug product may send the MAA pharmacist(s) a written request and the following supporting documentation:

- Background data about the drug;
- Product package information;
- Any pertinent clinical studies;
- Outcome and effectiveness data using the Academy of Managed Care Pharmacy's drug review submission process; and
- Any additional information the manufacturer considers appropriate.

MAA evaluates a drug based on, but not limited to, the following criteria:

- Whether the manufacturer has signed a federal drug rebate contract agreement;
- Whether the drug is a less-than-effective drug;
- The drug's risk/benefit ratio;
- Whether like drugs are on MAA's drug file list and there are less costly therapeutic alternative drugs;
- Whether the drug falls into one of the categories authorized by federal law to be excluded from coverage;
- The drug's potential for abuse; and
- Whether outcome data demonstrate that the drug is cost effective.

Prior authorization/reject edit conflict codes

The following table indicates the type of Reject Edit/Conflict Code providers will receive if they submit a POS claim for a drug that requires a prior authorization (PA) number.

VERSION 5.1

REJECT EDIT/ CONFLICT CODE	REASON REJECTED	ACTION
3S Missing/invalid PA supporting documentation. PA Required	Drugs requiring expedited prior authorization.	Pharmacy must submit using appropriate EPA# or call MAA for PA.
75 PA Required	Medications that require prior authorization.	Pharmacy must call MAA for PA.

Expedited prior authorization (EPA)
[Refer to WAC 388-530-1250(4)]

What is the EPA process?
MAA's EPA process is designed to eliminate the need to request authorization from MAA. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

How is an EPA number created?
To bill MAA for drugs that meet the expedited prior authorization (EPA) criteria on the following pages, the pharmacist must create a 9-digit EPA number. The first six digits of the EPA number must be **850000.** The last 3 digits must be the code number of the diagnosis/condition that meets the EPA criteria.

🗁**BILLING**:

Hardcopy billers must enter the EPA Number in the *Authorization Number* field on the Pharmacy Statement [DSHS 13-714]

Point of Sale billers must enter the EPA Number in the *Claims Segment, Prior Authorization Number Submitted* field.

Example: The 9-digit EPA number for Accutane (for the treatment of "severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy") would be **850000002** (850000 = first six digits, 002 = diagnosis/condition code).

Pharmacists are reminded that EPA numbers are only for those drugs listed <u>on the following pages</u>. They are not valid for:

- Other drugs requiring prior authorization through the Prescription Drug Program;
- Waiving the MAC price; or
- Authorizing the third or fifth fill in the month.

Note: Use of an EPA number does not exempt claims from Therapeutic Consultation Services (TCS) edits. See Section F.

Expedited Prior Authorization Guidelines:

A. **Diagnoses** - Diagnostic information may be obtained from the prescriber, client, client's caregiver, or family member to meet conditions for EPA. Drug claims submitted without an appropriate diagnosis/condition code for the dispensed drug are denied.

B. **Unlisted Diagnoses - If the drug is prescribed for a diagnosis/condition, or age that does not appear on the EPA list, the pharmacist must call the Pharmacy Prior Authorization toll-free number at 1-800-848-2842 to request authorization.**

C. **Documentation** - Dispensing pharmacists must write on the original prescription the full name of the person who provided the diagnostic information and the diagnosis/condition and/or the criteria code from the attached table. Documentation must be kept on file for six (6) years.

b.   Receives a delayed certification (see page K.2), the provider must:

        i.   Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and

      ii.   Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service; or

c.   Receives a retroactive certification (see page K.3), the provider:

        i.   Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and

      ii.   May refund any payment received from the client or anyone on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

> ☞   **Note:**   Many people apply for a medical program *AFTER* receiving covered medical services. The department may take as long as 45 to 90 days to process medical applications.
>
> If eligible, the client receives a DSHS Medical ID card dated the first of the month of application. The Medical ID card is *NOT* noted with either the "retroactive certification" or "delayed certification" identifiers. Providers must treat these clients as the "delayed certification" procedure described above, even if the patient indicated he or she was private pay on the date of medical service.

5.   Hospitals may not bill, demand, collect, or accept payment from a Medically Indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstances described in subsection 3.g. of this section.

6.   A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider.

This includes, but is not limited to:

(a)   Medical charts;
(b)   Radiological or imaging films; and
(c)   Laboratory or other diagnostic test results.

Hospice clients

Clients who have elected to receive hospice benefits are identified by an "**X"** in the hospice area on their DSHS Medical ID card.

Clients enrolled in the Hospice program **waive** services outside the Hospice program that are directly related to their terminal illness. All services related to their terminal illness must be coordinated by the designated hospice agency and attending physician **only**.

Services **not** related to their terminal illness may be provided to clients on a fee-for-service basis. When billing for hospice clients and the service is **not** related to the terminal illness, use the following billing procedures:

> 📁**BILLING**:
>
> **Hard copy billers** must enter "**K**" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].
>
> **Point-of-Sale billers** must enter "**11**" in the *Patient Segment, Patient Location* field.

📁**BILLING**:

Hard copy billers must enter one of the following comments in the *Justification/ Comments* field on the Pharmacy Statement [DSHS 13-714].

> **Prescribed by Family Planning Agency**
> **Prescribed by Community Mental Health Center; or**
> **Prescribed by Health Department**

Point-of-Sale billers must enter "**2**" in the *Claim Segment, Prior Authorization Type Code* field.

Family Planning Only and TAKE CHARGE clients

Clients on the Family Planning Only or TAKE CHARGE Programs are identified by the statement "Family Planning Only" or "TAKE CHARGE" on their DSHS Medical ID card.

Qualified agencies may prescribe family planning related drugs for sexually transmitted diseases (STD) (excluding HIV), abortion-related drugs, and prescription contraceptives within the following therapeutic drug classes:

> Analgesics
> Antibiotics
> Anti-emetics
> Antifungals
> Anti-infectives
> Anti-inflammatories
> Contraceptive drugs/devices
> Oxytocics

Skilled Nursing Facility clients

Over-the-Counter (OTC) Drugs

MAA does not reimburse for OTC drugs when the client resides in a skilled nursing facility. Reimbursement for OTC drugs is included in the skilled nursing facility per diem.

Medications for skilled nursing facility clients on leave

Skilled nursing facility clients on leave should have their additional maintenance prescriptions filled for the duration of the leave. If client leaves weekly, prescriptions should be filled for a one-month supply.

Skilled nursing facilities should determine which of the following methods will be followed when a skilled nursing facility client goes on leave:

- The client may take the prescription medication home and keep it there for use during skilled nursing facility absences; or

- The client may return the prescription medication to the skilled nursing facility following each leave so that it may be stored for safekeeping. The prescription medication is the client's personal property.

  Both of these practices are in accord with state pharmaceutical regulations.

🗀**BILLING**:

Hard copy billers must indicate "**weekend pass**" or "**take home/leave supply**" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers: Enter "8" in the *Claim Segment, Prior Authorization Type Code* field.

Emergency Kits

The *emergency kit* is a set of limited pharmaceuticals furnished to a skilled nursing facility by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the emergency needs of each skilled nursing facility's client population and is for use during those hours when pharmacy services are unavailable.

Medications supplied from the emergency kit are to be replaced by an equivalent amount of medications from the client's prescription by the skilled nursing facility. No charge shall be made to MAA for such replacements.

Skilled Nursing Facility Unit Dose Delivery Systems
[Refer to WAC 388-530-1550]

MAA recognizes two types of **Unit Dose Delivery Systems** for skilled nursing facilities:

➡️ **True Unit Dose Delivery System**
➡️ **Modified Unit Dose Delivery System**

Participating True Unit Dose and Modified Unit Dose providers receive the "unit dose dispensing fee" when dispensing in-house unit dose prescriptions. The term *in-house unit dose* applies to bulk pharmaceutical products that are packaged by the pharmacy for true or modified unit dose delivery. Only True Unit Dose providers will receive the unit dose dispensing fee for drugs that are manufacturer packaged in unit dose form (e.g., blister packs, punch cards, etc.). Modified Unit Dose providers will receive the regular pharmacy dispensing fee for drugs that are manufacturer packaged in unit dose form.

Refer to the Reimbursement Section of these billing instructions for MAA Dispensing Fee Allowances for pharmacies.

How do pharmacies become eligible for a unit dose dispensing fee?
[Refer to WAC 388-530-1600(1)]

To be eligible for a unit dose dispensing fee from MAA, a pharmacy must:

1. Notify MAA in writing of its intent to provide unit dose service;
2. Specify the type of unit dose service to be provided;
3. Identify the nursing facility or facilities to be served;
4. Indicate the approximate date unit dose service to the facility or facilities will commence; and
5. Sign an agreement to follow department requirements for unit dose reimbursement.

For information on becoming a True Unit Dose or a Modified Unit Dose provider, please call Provider Enrollment at (866) 545-0544 or send a written request to:

Medical Assistance Administration
Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

How do pharmacies bill MAA under a true or modified unit dose delivery system? [Refer to WAC 388-530-1600(2)(3)(4)]

Under a true unit dose delivery system, a pharmacy must bill MAA only for the number of drug units actually used by the MAA client in the skilled nursing facility.

Under a modified unit dose delivery system, a pharmacy must bill MAA for the number of drug units dispensed to the MAA client in the skilled nursing facility.

It is the unit dose pharmacy provider's responsibility to coordinate with the skilled nursing facilities to ensure that the unused drugs the pharmacy dispensed to the MAA client are returned to the pharmacy for credit.

The pharmacy must submit an adjustment form or claims reversal of the charge to MAA for the cost of all unused drugs returned to the pharmacy from the skilled nursing facility on or before the 60th day following the date the drug was dispensed. This adjustment must conform to the skilled nursing facility's monthly log.

Exception:

➢   Unit dose providers do not have to credit MAA for federally designated schedule II drugs that are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

📂**BILLING**:

Hard copy billers must indicate "**In-house unit dose**" in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers: Enter "3" in the *Claim Segment, Unit Dose Indicator* field.

- **Other coverage exists – payment collected**
  If you have billed a primary insurance and are "balance billing" to Medical Assistance, you must have an amount entered into the *Other Payer Amount Paid* field, and **enter a 2** in the *Other Coverage Code* field to indicate the payment was collected. Hardcopy billers must enter other coverage code 2 in the *Justification/ Comments* field.

- **Other coverage exists – this claim not covered**
  This is necessary when you bill the insurance carrier and receive a denial or your claim is paid at $0.00. A $0.00 payment occurs if the primary payer applies a deductible, the prescription cost is less than the copayment amount, or other insurance conditions for nonpayment apply. **Enter a 3** in the *Other Coverage Code* field and the date the claim was denied (or paid at $0.00) in the *Other Payer Date* field. Hardcopy billers must enter other coverage code in the *Justification/Comments* field.

- **Other coverage exists – not in effect at time of service**
  This is sued if the provider bills the insurance for a non-covered date of service. This often occurs when the insurance is union based and has lapses in coverage, or the coverage has terminated. **Enter a 7** in the *Other Coverage Code* field. Hardcopy billers must enter other coverage code 7 in the *Justification/Comments* field.

- **Capitated contracted copayments** – This is for capitated service agreements that some providers have with insurance companies. The provider collects copayments (fee-for-service payment is not applicable for this service.) When the service being billed to the department is under a capitated service agreement, enter only the copayment amount in the *Usual and Customary Charge* field and in the *Gross Amount Due* field. Because the third party carrier did not pay a fee-for-service amount, **do not** enter an amount in the *Other Payer Amount Paid* field. **Enter an 8** in the *Other Coverage code* field. Hardcopy billers must enter other coverage code 8 in the *Justification/Comments* field. This is the only circumstance appropriate to use the 8. By entering an 8 you are certifying that this is a capitated amount and that a fee-for-service payment was not received for the service.

  Note: In this instance, the normal 34 day supply limit may be exceeded.

- **Primary insurance billing exceptions**

  Situations may occur when a client is out of the HMO service area or HMO coverage is not accessible. After making reasonable attempts to access the primary coverage, a pharmacy provider may proceed to meet the client's immediate needs.

  An exception to regular POS insurance billing requirements is allowed for Medical Assistance clients whose insurance company requires the client to pay before receiving prescriptions. To enable these clients to receive their medications, MAA will pay the lesser of the billed amount or the Medicaid allowed amount. In these prepay situations **do not** bill the insurance company. Bill these claims directly to MAA.

  In the instances described above, please call MAA's Coordination of Benefits Section at 1-800-562-6136 for billing assistance.

How to bill for clients who are eligible for both Medicare and Medicaid

Some Medicaid clients are also eligible for Medicare benefits. Benefits under Part B Medicare now cover some drugs and related supplies. When you have a client who is eligible for both Medicaid *and* Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier *first*. Medicare is the primary payer of claims.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when: (1) the provider accepts assignment, and (2) the total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount. MAA will pay up to Medicare's allowable or MAA's allowable, whichever is less.

An **X** in the *Medicare* column on the client's Medical ID card indicates Medicare eligibility.

> **QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)**
>
> (Clients who have CNP or MNP identifiers on their Medical ID card in addition to QMB)
>
> - If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
> - If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
> - If Medicaid covers the service and Medicare does not cover the service, MAA will reimburse for the service.

After Medicare has processed your claim, and if Medicare has allowed the service(s), in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent*," appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

- If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, bill MAA.

> **You must submit your claim to MAA within**
> *six months* **of the Medicare statement date.**

- If **Medicare denies** a service, bill MAA through the POS system using the appropriate DUR outcome code (see pages K.5 and K.6). Claims may also be billed on the Pharmacy Statement form and must have the Medicare denial letter or Explanation of Benefits (EOMB) attached. [Note: When Medicare denies a service that requires prior authorization, MAA waives the *prior* requirement, but authorization is still required.]

**Do not bill MAA for Medicare's coinsurance and deductible
through the on-line POS system.
For detailed POS billing instructions, see Section K.**

How do I bill for a baby who is using his/her parent's PIC?

📁**BILLING**:

Hard copy billers must indicate "**Baby using parent's PIC**" in the *Justification/ Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers: Enter "**2**" in the *Insurance Segment, Eligibility Clarification Code* field.

Point-of-Sale (POS)

What is Point-of-Sale (POS)?

The POS system is an on-line, real time, pharmacy claims processing system. Since the POS is online, each attempt to process a claim will appear on your weekly Remittance and Status Report (RA). Please be sure to track each transaction completely before contacting MAA. A claim that is rejected and subsequently paid on the same RA will have an Explanation of Benefits (EOB) 402 attached to the claim(s). The POS system uses the National Council for Prescription Drug Programs (NCPDP) version 5.1 format.

Any claim that requires a hard copy attachment must be submitted as a paper claim.

Do pharmacies have to use the on-line POS system?

No! Pharmacies that choose not to use the on-line POS system can submit their claims through hard copy billing (paper claims). These claims will be processed by MAA through the POS system. All prescription drug claims are processed and edited through the POS system regardless of how they are submitted.

Do pharmacies need a separate agreement with MAA to use POS?

No! A separate agreement with MAA is not required to use POS. Simply contact your switch-vendor or software vendor.

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit initial claims and adjust prior claims in a timely manner. The following is MAA's timeliness standards for initial claims and for resubmitted claims for the Prescription Drug Program:

- ## Initial Claims

    - ✓ MAA requires providers to submit an **initial claim** to MAA and have an Internal Control Number (ICN) assigned by MAA within 365 days from any of the following:

        - ➢ The date the provider furnishes the service to the eligible client;
        - ➢ The date a final fair hearing decision is entered that impacts the particular claim;
        - ➢ The date a court orders MAA to cover the services; or
        - ➢ The date DSHS certifies a client eligible under delayed[1] certification criteria.

    ☞ **Note:** If MAA has recouped a managed care plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

    Medicare Crossover Claims: If Medicare allows the claim, the provider must bill MAA within six months of the date Medicare processes the claim. If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for the initial claim.

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1 **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

    ✓   **MAA may grant exceptions to the 365 day time limit for** initial claims **when billing delays are caused by either of the following:**

> ➢   DSHS certification of a client for a retroactive[2] period; or
> ➢   The provider proves to MAA's satisfaction that there are other extenuating circumstances.

    ✓   MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

• Resubmitted Claims

MAA allows providers to resubmit, modify, or adjust any prescription drug claim with a timely ICN within 15 months of the date the service was provided to the client. After 15 months, MAA does not accept a prescription drug claim for resubmission, modification, or adjustment.

• Overpayments that must be refunded to DSHS

The 15-month period for resubmitted claims above does not apply to overpayments that a prescription drug provider must refund to DSHS. After 15 months, a provider must refund overpayments by a negotiable financial instrument, such as a bank check. **Do not do a claim adjustment.**

• Billing the Client

MAA does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements in this section, resulting in the claim not being paid by MAA. **[See "Billing a Client," page J.4.]**

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2 **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

National Drug Code (NDC)

The NDC is the 11-digit code assigned to all prescription drug products by the labeler or distributor of the product under FDA regulations.

> **The provider <u>must</u> use the <u>actual</u>, complete 11-digit NDC from the dispensing container.** [Refer to WAC 388-530-1800(1)(b)]

MAA accepts only the 5-4-2 NDC format. ***All 11 digits, including zeros, must be entered***. The three segments of the NDC are:

> **SAMPLE NDC: 12345-6789-10**
> **12345 = labeler code**
> **6789 = product code**
> **10 = package size**

Prospective Drug Use Review (Pro-DUR)

MAA is providing a system-facilitated Prospective Drug Use Review screening as a part of the POS system. High Dose and Therapeutic Duplication edits post and claims are rejected when potential drug therapy problems are identified. Once pharmacists have conducted their professional review, MAA recognized NCPDP DUR Reason for Service, Professional Service, and Result of Service codes can be used to override the Pro-DUR edits.

When appropriate, enter one of the NCPDP DUR codes from each of the categories in the appropriate POS field. By placing the information on the claim, the provider is certifying that the indicated DUR code is true and documentation is on file. POS claims coding is subject to MAA review/audit.

Hardcopy (paper) claims must note the appropriate DUR Conflict Code in the *Justification/ Comments* field on the Pharmacy Statement [DSHS 13-714], if applicable.

MAA Recognized NCPDP DUR Codes

Reason for Service Code
(Formerly DUR Conflict Code)

AT	Addictive Toxicity
CH	Call Help Desk
DA	Drug Allergy
DC	Drug Disease (Inferred)
DD	Drug Drug Interaction
DF	Drug Food Interaction
DI	Drug Incompatibility
DL	Drug Lab Conflict
DS	Tobacco Use
ER	Overuse
HD	High Dose
IC	Iatrogenic Condition
ID	Ingredient Duplication
LD	Low Dose
LR	Underuse
MC	Drug Disease (Reported)
MN	Insufficient Duration
MX	Excessive Duration
OH	Alcohol Conflict
PA	Drug Age
PG	Drug Pregnancy
PR	Prior Adverse Reaction
SE	Side Effect
SX	Drug Gender
TD	Therapeutic Duplication

Professional Service Code
(Formerly DUR Intervention Code)

M0 (M, ZERO)	Prescriber consulted
P0 (P, ZERO)	Patient consulted
R0 (R, ZERO)	Pharmacist consulted other source

Result of Service Code
(Formerly DUR Outcome Code)

1A	Filled as is, false positive
1B	Filled as is or filled for Medicare/Medicaid dual-eligible client following Medicare denial
1C	Filled with different dose
1D	Filled with different directions
1F	Filled with different quantity
1G	Filled after prescriber approval obtained

Prospective Drug Use Review (Pro-DUR) Edits

The following charts outline potential reject edits. The description, reason for the edit, and necessary action are indicated.

REJECT EDIT/ CONFLICT CODE	REASON	ACTION
88 HD	High Dose Alert Any drug to be dispensed in excess of the maximum daily dose	Pharmacist should verify that the quantity and/or day's supply was entered correctly. Pharmacist may need to contact the prescriber regarding appropriate prescribed quantity. NCPDP Pro-DUR codes can be used to certify the indicated situation exists.
88 TD	Therapeutic Duplication Alert Concurrent prescriptions for drugs in the same therapeutic class.	Pharmacist should use professional judgement or confer with prescriber to determine appropriateness of duplicate therapy.

Other Prospective Drug Use Review Edits

REJECT EDIT	REASON	ACTION
60	Age alert Client age inappropriate for drug.	Verify client age or call 1-800-848-2842 for authorization.
66	Age alert Client age exceeds maximum for drug.	Verify client age or call 1-800-848-2842 for authorization.
79	Refill too soon. Previous supply dispensed has not been exhausted.	If increase in dose, enter appropriate NCPDP DUR codes. Otherwise, call 1-800-848-2842 for authorization.
83	Duplicate claim Previous claim paid for same drug.	If same drug, different strength, the pharmacist should check prescriber ID field and enter prescriber ID on each claim (for both strengths). If different prescribers, pharmacist must call 1-800-848-2842 for authorization.

NCPDP Version 5.1 Claim Format

In order to comply with the Health Insurance and Accountability Act (HIPAA) requirements, **effective for dates of service on and after October 16, 2003, the Medical Assistance Administration (MAA) will require all pharmacy providers to use NCPDP Version 5.1 claim format** when submitting Point-of-Sale (POS) claims.

The NCPDP Version 5.1 Claim Format/General Information

- Defines the record layout for real-time prescription claim transactions between providers and processors;
- Is a variable format;
- Up to four transactions per transmission are accepted (except when billing compounds, only one transaction is allowed per transmission);
- Includes the following changes:

  - 86 new data fields;
  - 23 existing data fields that have been expanded;
  - Allowance for pharmacy providers to submit a claim with a total charge of up to $999,999.99; and
  - Allowance for pharmacy providers to submit a claim with a quantity dispensed up to 9,999,999.999 units.

- The Payer Sheet Status Indicators have changed:

  - M = Mandatory per the NCPDP standard
  - R =Required per MAA
  - RW = Required When (these fields depend on other fields to determine if they are required)
  - (Repeating) = there can be more than one response entered (Example: Reason for Service Code field)

Additional Features of the NCPDDP Version 5.1 Claim Format
The NCPDP Version 5.1 Claim Format allows for two additional functions: submission of partial fills and multi-line compounds.

Transaction Header Segment
The Transaction Header Segment is mandatory on all transactions and all fields within the segment are mandatory. The fields must also be submitted in the order they appear.

The Transaction Header Segment tells the system where to send the claim, what type of submission it is, how many transactions, who is submitting the claim, date of service, and the vender certification number.

Insurance Segment
The Insurance Segment is mandatory on most incoming transmissions. It is not required for reversals; it is mandatory on all others.

This segment contains data describing the Medical Assistance client (cardholder). Only the Segment Identification field and Patient Identification Code (PIC) are mandatory.

Claim Segment
The Claim Segment is mandatory on all transmissions except Eligibility Verification. This segment contains data relating to the actual prescription dispensed or the professional service performed. The Claim Segment is also used to identify a partially filled prescription.

In order to submit a claim for a partially filled prescription, the following must be done:

- The Initial Fill 'P' and Completion Fill 'C' must originate from the same provider and both must have the same Prescription Service/Reference number and Fill Number;
- An Initial Fill can exist without a Completion Fill but a Completion Fill cannot exist without an Initial Fill;
- Only one Initial Fill and Completion Fill can be accepted for a single Product/Service ID;
- If you have sent in an Initial Fill and find that you can complete the entire fill on the same day, reverse the Initial Fill, then resubmit with the total quantity dispensed;
- Dispensing Status 'P' will be required on an Initial Fill along with quantity and days supply to be dispensed. This requirement applies to the original claim and a reversal of an Initial Fill claim;
- Dispensing Status 'C' will be required on the Completion Fill, along with the Associated Prescription/Service Reference Number and Associated Prescription/Service Date. This requirement applies to the original claim and a reversal of the completion of a partial fill;
- An edit has been added to deny a claim when the total quantity to be dispensed on the Initial Fill and Completion Fill exceeds the quantity intended to be dispensed;
- When reversing a partial fill transaction, the Completion Fill transaction must be reversed before the Initial Fill transaction is reversed; and
- The dispensing fee is paid to the providers at the time of the Initial Fill.

Pricing Segment

The Pricing Segment is required on all incoming billing and rebilling transactions. This segment contains data describing how the product is to be priced. The mandatory/required fields are: Segment Identification, Ingredient Cost Submitted, Usual and Customary Charge, and Gross Amount Due.

Pharmacy Segment

Not used by MAA at this time.

Prescriber Segment

The Prescriber Segment contains data describing the prescriber and is required on all incoming transmissions. The mandatory/required fields are the Segment Identification, Prescriber ID Qualifier, and Prescriber ID. This segment is not required on claim reversals.

COB/Other Payment Segment

This segment is not mandatory for any claim transaction. It may be required in some situations when billing or rebilling. The COB/Other Payments Segment contains information indicating the presence of other payers or insurers.

This segment is mandatory/required when the pharmacist or MAA indicates other coverage. If the segment is not included on the transmission, appropriate COB exceptions will be posted on the claim.

Use the Other Coverage Code field in the Claim Segment to indicate insurance coverage information. Refer to J.16-J.18.

Compound Segment

This segment allows for the multi-line submission of compounds. The Compound Segment may only be submitted on billing or rebilling. This segment is not sent on claim reversals. Information describing the compound ingredients is included here. If the segment is submitted, the Segment Identification, Compound Dosage Form Description Code, Compound Dispensing Unit Form Indicator, Compound Route of Administration and Compound Ingredient Component Count are mandatory fields. Also mandatory are the Compound Product ID Qualifier, Compound Product ID, and Compound Ingredient Quantity. The previous three fields may repeat one time for each ingredient in the compound. Up to 40 separate ingredients will be accepted. MAA will reimburse a dispensing fee for each payable ingredient. Each line will be adjudicated separately and will be subject to all applicable edits, including prior authorization. Compounds may not be submitted as a partial fill, either as the Initial Fill or Completion Fill.

DUR/PPS Segment

The DUR/PPS Segment contains data pertinent to the DUR edit being resolved. The Result of Service Code was formerly called DUR Outcome Code and is a Required When field. A value of 1C is used to override a Refill Too Soon reject when there is a dosage change. A value of 1B is used for a Medicare/Medicaid dual-eligible client to indicate a Medicare denial.

Prior Authorization Segment

Not used by MAA at this time.

Patient Segment

The Patient Segment is situational on all incoming transmissions. The Patient Location is a Required When (RW) field. Enter:

01   to indicate the client resides at home, in an assisted living facility, group home, or adult family home;

02   to indicate an ITA claim;

03   to indicate the client resides in a skilled nursing facility; or

11   to indicate a hospice patient whose claim is unrelated to their terminal condition.

Clinical Segment

Not used by MAA at this time.

Worker's Compensation Segment

Not used by MAA.

Coupon Segment

Not used by MAA at this time.

NCPDP Payer Sheet for Washington Medicaid
Version 5.1

Field	Field Name	Status	Picture	Values
Transaction Header Segment				
101-A1	Bin Number	M	9(6)	610084
102-A2	Version/Release Number	M	X(2)	51
103-A3	Transaction Code	M	X(2)	B1 = Billing B2 = Reversal B3 = Rebill
104-A4	Processor Control Number	M	A(10)	DRWAPROD for Production DRWAACCP for Test
109-A9	Transaction Count	M	X(1)	1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences
202-B2	Service Provider ID Qualifier	M	X(2)	07 = NCPDP (NABP) ID
201-B1	Service Provider ID	M	X(15)	NCPDP (NABP) Provider ID
401-D1	Date of Service	M	9(8)	CCCYYMMDD
110-AK	Software Vendor/Certification ID	M	X(10)	Populate with Cert Number provided by Switch Vendor, otherwise enter zeroes
Insurance Segment				
111-AM	Segment Identification	M	X(2)	04 = Insurance
302-C2	Cardholder ID	M	X(20)	Enter client's 14-character Medicaid Patient ID Code (PIC)
309-C9	Eligibility Clarification Code	RW	9(1)	Enter '2' to indicate a claim where baby is using parent's PIC
301-C1	Group ID	R	X(15)	2507850
306-C6	Patient Relationship Code	R	X(1)	Enter '1'
Claim Segment				
111-AM	Segment Identification	M	X(2)	07 = Claim
455-EM	Prescription/Service Reference Qualifier	M	X(1)	1 = Rx Billing

NCPDP Payer Sheet for Washington Medicaid
Version 5.1

Field	Field Name	Status	Picture	Values
402-D2	Prescription/Service Reference Number	M	X(7)	Reference number assigned by the provider for the dispensed drug
436-E1	Product/Service ID Qualifier	M	X(2)	03 = NDC
407-D7	Product/Service ID	M	X(19)	11-digit NDC number
456-EN	Associated Prescription/Service Reference Number	RW	9(7)	Required when billing for a partial fill
457-EP	Associated Prescription/Service Date	RW	9(8)	CCYYMMDD Required when billing for a partial fill
442-E7	Quantity Dispensed	R	9(7)v999	Metric quantity
403-D3	Fill Number	R	9(2)	0 = Original dispensing 1-99 = Refill number
405-D5	Days Supply	R	9(3)	Estimated number of days that the prescription will last
406-D6	Compound Code	RW	9(1)	2 = Compound claim
408-D8	Dispense as Written (DAW)/Product Selection Code	RW	X(1)	0 = No product selection 1 = Physician request
414-DE	Date Prescription Written	M	9(8)	CCYYMMDD
308-C8	Other Coverage Code	RW	9(2)	0 = Not specified 1 = No other coverage 2 = Other coverage exists, payment collected 3 = Other coverage exists, claim not covered 7 = Other coverage exists, not in effect at time of service 8 = Capitated contracted co-payments
429-DT	Unit Dose Indicator	RW	9(1)	3 = Pharmacy unit dose
461-EU	Prior Authorization Type Code (Formerly Medical Certification Code)	RW	9(2)	2 = Self-referred Healthy Options client 5 = Lost or stolen medication replacement 8 = Supply for take home, school or camp, suicide risk or monitoring
462-EV	Prior Authorization Number Submitted	RW	9(11)	Prior Authorization Number or Expedited Authorization Number

NCPDP Payer Sheet for Washington Medicaid
Version 5.1

Field	Field Name	Status	Picture	Values
343-HD	Dispensing Status	RW	X(1)	P = Initial fill C = Completion fill
344-HF	Quantity Intended to be Dispensed	RW	9(7)v(9)3	Used when submitting a claim for a partial fill
345-HG	Days Supply Intended to be Dispensed	RW	9(3)	Used when submitting a claim for a partial fill
Pricing Segment				
111-AM	Segment Identification	M	X(2)	11 = Pricing
409-D9	Ingredient Cost Submitted	R	S9(6)v99	
426-DQ	Usual and Customary Charge	R	S9(6)v99	Amount charged cash customers for the prescription exclusive of sales tax For Public Health Service entities, usual and customary charge is the "actual acquisition cost"
430-DU	Gross Amount Due	R	S9(6)v99	Total price claimed from all sources
Pharmacy Segment (Not used by MAA at this time)				
111-AM	Segment Identification	M	X(2)	07 = Claim
Prescriber Segment				
111-AM	Segment Identification	M	X(2)	03 = Prescriber
466-EZ	Prescriber ID Qualifier	R	X(2)	05 = Medicaid ID 08 = DEA number
411-DB	Prescriber ID	R	X(15)	Enter Medicaid ID or DEA number as appropriate
COB/Other Payment Segment				
111-AM	Segment Identification	M	X(2)	05 = COB
337-4C	COB/Other Payment Count	M	9(1)	

NCPDP Payer Sheet for Washington Medicaid
Version 5.1

Field	Field Name	Status	Picture	Values
388-5C	Other Payer Coverage Type	M (Repeating)	X(2)	01 = Primary 02 = Secondary 03 = Tertiary 98 = Coupon 99 = Composite
339-6C	Other Payer ID Qualifier	RW (Repeating)	X(2)	01 = National Payer ID 02 = Health Industry Number (HIN) 03 = Bank Information Number (BIN) 04 = National Association of Insurance Commissioners (NAIC) 09 = Coupon 99 = Other
340-7C	Other Payer ID	RW (Repeating)	X(10)	
443-E8	Other Payer Date	RW	9(8)	CCYYMMDD
342-HC	Other Payer Amount Paid Qualifier	RW (Repeating)	X(2)	Blank = Not specified 01 = Delivery 02 = Shipping 03 = Postage 04 = Administrative 05 = Incentive 06 = Cognitive service 07 = Drug benefit 08 = Sum of all reimbursement 98 = Coupon 99 = Other
431-DV	Other Payer Amount Paid	RW (Repeating)	S9(6)v99	S$$$$$$cc

NCPDP Payer Sheet for Washington Medicaid
Version 5.1

Field	Field Name	Status	Picture	Values
	Compound Segment			
111-AM	Segment Identification	M	X(2)	10 = Compound
450-EF	Compound Dosage Form Description Code	M	X(2)	01 = Capsule 02 = Ointment 03 = Cream 04 = Suppository 05 = Provider 06 = Emulsion 07 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema
451-EG	Compound Dispensing Unit Form Indicator	M	9(1)	1 = Each 2 = Gram 3 = Milliliter
452-EH	Compound Route of Administration	M	9(2)	00 = Not specified 01 = Buccal 02 = Dental 03 = Inhalation 04 = Injection 05 = Intraperitoneal 06 = Irrigation 07 = Mouth/throat 08 = Mucous membrane 09 = Nasal 10 = Ophthalmic 11 = Oral 12 = Other 13 = Otic 14 = Perfusion 15 = Rectal 16 = Sublingual 17 = Topical 18 = Transdermal 19 = Translingual 20 = Urethral 21 = Vaginal 22 = Enteral

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Field	Field Name	Status	Picture	Values
447-EC	Compound Ingredient Component Count	M (Repeating)	9(2)	Count of compound product ID's (NDC's)
488-RE	Compound Product ID Qualifier	M (Repeating)	X(2)	03 = NDC
489-TE	Compound Product ID	M (Repeating)	X(19)	11-digit NDC number
448-ED	Compound Ingredient Quantity	M (Repeating)	9(7)v999	Metric quantity
DUR/PPS Segment				
111-AM	Segment Identification	M	X(2)	08 = DUR/PPS
439-E4	Reason for Service Code (Formerly DUR Conflict Code)	RW (Repeating)	X(2)	AT = Additive toxicity CH = Call Help Desk DA = Drug allergy DC = Drug disease (inferred) DD = Drug-drug interaction DF = Drug-food interaction DI = Drug incompatibility DL = Drug-lab conflict DS = Tobacco use ER = Overuse HD = High dose IC = Iatrogenic condition ID = Ingredient duplication LD = Low dose LR = Underuse MC = Drug disease (reported) MN = Insufficient duration MX = Excessive duration OH = Alcohol conflict PA = Drug age PG = Drug pregnancy PR = Prior adverse reaction SE = Side effect SX = Drug gender TD = Therapeutic duplication
440-E5	Professional Service Code (Formerly DUR Intervention Code)	RW (Repeating)	X(2)	M0 (M, zero) = Prescriber consulted P0 (P, zero) = Patient consulted R0 (R, zero) = Pharmacist consulted other source

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Field	Field Name	Status	Picture	Values
441-E6	Result of Service Code (Formerly DUR Outcome Code)	RW (Repeating)	X(2)	1A = Filled as is, false positive 1B = Filled as is (Enter 1B for a Medicare/Medicaid dual-eligible client following Medicare denial) 1C = Filled with different dose (Enter 1C to override a Refill Too Soon edit for a dosage change) 1D = Filled with different directions 1F = Filled with different quantity 1G = Filled after prescriber approval obtained

Prior Authorization Segment (Not used by MAA at this time)

Field	Field Name	Status	Picture	Values
111-AM	Segment Identification	M	X(2)	12 = Prior authorization
498-PA	Request Type	M	X(1)	1 — 4
498-PB	Request Period Date – Begin	M	9(8)	CCYYMMDD
498-PC	Request Period Date – End	M	9(8)	CCYYMMDD
498-PD	Basis of Request	M	X(2)	ME, PR, PL

Patient Segment

Field	Field Name	Status	Picture	Values
111-AM	Segment Identification	M	X(2)	01 = Patient
304-C4	Date of Birth	R	9(8)	CCYYMMDD
307-C7	Patient Location	RW	9(2)	01 = Client resides at home, in an assisted living facility, group home, or adult family home 02 = ITA claim 03 = Client resides in a skilled nursing facility 11 = Hospice patient whose prescription is unrelated to their terminal condition
335-2C	Pregnancy Indicator	RW	X(1)	1 = Not pregnant 2 = Pregnant

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Field	Field Name	Status	Picture	Values
Clinical Segment (Not used by MAA at this time)				
111-AM	Segment Identification	M	X(2)	13 = Clinical
Worker's Compensation Segment (Not used by MAA at this time)				
111-AM	Segment Identification	M	X(2)	06 = Worker's compensation
Coupon Segment (Not used by MAA at this time)				
111-AM	Segment Identification	M	X(2)	09 = Coupon

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are <u>inappropriate</u> entries for field 9.

10. **<u>Is Patient's Condition Related To</u>**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **<u>Insured's Policy Group or FECA (Federal Employees Compensation Act) Number</u>**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **<u>Insured's Date of Birth</u>**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **<u>Employer's Name or School Name</u>**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **<u>Insurance Plan Name or Program Name</u>**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **<u>Is There Another Health Benefit Plan?</u>:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d is left blank, the claim may be processed and denied in error.**

19. **<u>Reserved For Local Use</u> - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **<u>Medicaid Resubmission</u>**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **<u>Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form</u>**.

24a. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY)**

24b. **Place of Service**: Required. Enter a **99**.

24d. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter **appropriate HCPCS**.

Coinsurance and Deductible: Required. Enter the total combined coinsurance and deductible for each service in the space to the right of the modifier on each detail line.

24e. **Diagnosis Code**: Required. Enter appropriate diagnosis code for condition.

24f. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24g. **Days or Units**: Required. Enter the appropriate units.

24k. **Reserved for Local Use**: Required. Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: Required. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

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32. <u>**Name and Address of Facility Where Services Are Rendered**</u>: Required. Enter Medicare Statement Date **and** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. <u>**Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**</u>: Required. Enter the pharmacy's *Name, Address,* and *Phone #* on all claim forms. Enter your seven-digit pharmacy provider number (which usually begins with six [6]) here. **Do not use your NABP number for Medicare/Medicaid crossover claims.**

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

☐☐ PICA
PICA ☐☐

1. MEDICARE ☐ (Medicare #)　MEDICAID ☐ (Medicaid #)　CHAMPUS ☐ (Sponsor's SSN)　CHAMPVA ☐ (VA File #)　GROUP HEALTH PLAN ☐ (SSN or ID)　FECA BLK LUNG ☐ (SSN)　OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER　(FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY　SEX M ☐　F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED　Self ☐　Spouse ☐　Child ☐　Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY　STATE

8. PATIENT STATUS　Single ☐　Married ☐　Other ☐
Employed ☐　Full-Time Student ☐　Part-Time Student ☐

CITY　STATE

ZIP CODE　TELEPHONE (Include Area Code) ( )

ZIP CODE　TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS)　YES ☐　NO ☐

a. INSURED'S DATE OF BIRTH MM | DD | YY　SEX M ☐　F ☐

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY　SEX M ☐　F ☐

b. AUTO ACCIDENT?　PLACE (State)　YES ☐　NO ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?　YES ☐　NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?　YES ☐　NO ☐　*If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE　I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____　DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM | DD | YY　ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY　FROM　TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY　FROM　TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?　$ CHARGES　YES ☐　NO ☐

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. |___.___　3. |___.___
2. |___.___　4. |___.___

22. MEDICAID RESUBMISSION CODE　ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.

A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER　SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)　YES ☐　NO ☐

28. $ TOTAL CHARGE

29. $ AMOUNT PAID

30. $ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED _____　DATE _____

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN#　GRP#

PHYSICIAN OR SUPPLIER INFORMATION